RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: March 6, 2017
MAHS Docket No.: 16-017987
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and upon the Petitioner's request for a hearing.

After due notice, a telephone hearing was held on February 2, 2016. [redacted] Petitioner's daughter and power of attorney, appeared and testified on Petitioner's behalf. [redacted] the owner of the [redacted]) home where Petitioner lives, also testified as a witness for Petitioner. [redacted], Assistant Director of [redacted], appeared and testified on behalf of the Respondent [redacted], Clinical Manager; [redacted] Nursing Facility Transition (NFT) Team Lead; and [redacted], social worker/supports coordinator; testified as witnesses for Respondent.

ISSUE

Did Respondent improperly deny a request by Petitioner for additional services?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Respondent is a contract agent of the Michigan Department of Health and Human Services and is responsible for waiver eligibility determinations and the provision of MI Choice waiver services in its service area.

2. On November 14, 2016, Respondent received a NFT referral with respect to Petitioner. (Exhibit B, page 5).

3. On November 15, 2016, an intake screening was completed with Petitioner's representative. (Exhibit B, pages 4-5).

4. Petitioner passed the screening, but, as Respondent was at program capacity, she was also placed on a waiting list due to lack of available slots in the program. (Exhibit B, page 4).

5. Petitioner's daughter was verbally informed of that placement. (Exhibit B, page 4).

6. That same day, Respondent also sent Petitioner written notice that she had been placed on the waiting list because Respondent was currently at program capacity. (Exhibit A, page 1).

7. On November 18, 2016, [redacted] met with Petitioner's family and, during that meeting, Petitioner's family waived having a separate person-centered planning meeting and indicated that their sole goal was moving Petitioner to [redacted] (Exhibit B, page 4).

8. [redacted] also began crafting a per diem agreement for services based on conversation with family. (Exhibit B, page 3).

9. On November 30, 2016, [redacted] provided Petitioner's daughter with the approved per diem rate and advised her of the next steps in the process, which depended on whether [redacted] accepted the rate and an anticipated request for supplement from the family. (Exhibit B, page 3).

10. That same day, [redacted] also advised [redacted] of the approved per diem rate and asked its owner to let her know whether the rate was acceptable or not. (Exhibit B, page 3).

11. An assessment was also scheduled for December 2, 2016, but it had to be rescheduled for December 6, 2016 because the per diem rate had not yet been processed. (Exhibit B, page 3).

12. On December 1, 2016, Petitioner's representative advised [redacted] that the family was requesting an alternate care manager and a different per diem. (Exhibit B, page 2).

13. That same day, [redacted], the owner of [redacted] informed Ms. [redacted] that the per diem rate was not accepted because it was too low. (Exhibit B, page 2).

14. On December 5, 2016, at approximately 8:33 p.m. [redacted] and Ms. [redacted] spoke again on the telephone and, during that conversation, [redacted] asked when Petitioner was moving into the [redacted] Ms. [redacted] responded that she would not be as the per diem was rejected; and Ms. [redacted] that she was fine proceeding forward as Petitioner's representative was appealing the case. (Exhibit B, page 1).

15. Soon after that conversation, [redacted] and Petitioner's representative had a telephone conversation, during which [redacted] indicated that the December 6, 2016 assessment had been cancelled because the per diem had been rejected; Petitioner's representative stated that she would come up with the difference between the per diem rate, Petitioner's income, and what the [redacted] home was asking for; and Petitioner's representative asked for an assessment. (Exhibit B, page 2).

16. On December 8, 2016, the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter.

17. In that request, Petitioner and her representative state that the assessment and payment determination made in this case are inaccurate as they do not reflect Petitioner's actual needs.

18. On December 14, 2016, Petitioner was assessed and enrolled in the waiver program. (Testimony of Respondent's representative).

19. Petitioner's representative signed the per diem rate of [redacted] that same day. (Testimony of [redacted]).

20. The per diem rate included assessing with bathing, dressing, a.m. care, p.m. care, transferring, and toileting. (Testimony of [redacted]).

21. The [redacted] home also accepted the per diem rate at that time, but its owner did not believe the rate to be sufficient and she advised Respondent of differences between its assessment and Respondent's. (Testimony of Ms. [redacted]).

22. As of February 18, 2017, Absolute [redacted] will no longer be part of Respondent's provider network. (Testimony of Respondent's representative).

23. The AFC is appealing that determination. (Testimony of Ms. [redacted].

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations. It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

Petitioner is seeking services through the Department's Home and Community Based Services for Elderly and Disabled. The waiver is called MI Choice in Michigan. The program is funded through the federal Centers for Medicare and Medicaid to the

Michigan Department of Health and Human Services. Regional agencies, in this case Respondent, function as the Department's administrative agency.

> Waivers are intended to provide the flexibility needed to enable States to try new or different approaches to the efficient and cost-effective delivery of health care services, or to adapt their programs to the special needs of particular areas or groups of recipients. Waivers allow exceptions to State plan requirements and permit a State to implement innovative programs or activities on a time-limited basis, and subject to specific safeguards for the protection of recipients and the program. Detailed rules for waivers are set forth in subpart B of part 431, subpart A of part 440 and subpart G of part 441 of this chapter.
>
> *42 CFR 430.25(b)*

The Medicaid Provider Manual (MPM) outlines the governing policy for the MI Choice Waiver program and, with respect to nursing facility transitions; services in general; providers; and adequate action notices; the MPM states in part:

> **SECTION 5 - NURSING FACILITY TRANSITIONS**
>
> The process of transitioning nursing facility residents to a home or a community-based setting is a priority of MI Choice. The tenet of rebalancing the spectrum of long-term care services in Michigan was given impetus by the 1999 United States Supreme Court decision in Olmstead v. L. C.. MDHHS provides mechanisms to ensure an individual resides in the most independent setting.
>
> **5.1 TRANSITION CANDIDATES**
>
> Initial transition work begins prior to enrollment into the MI Choice program and often occurs before the verification of Medicaid eligibility. Candidates for Community Transition Services are nursing facility residents who have expressed a preference to live at home or in a community-based setting and who have barriers to transitioning that cannot be addressed through standard discharge procedures available to nursing facility staff. Nursing facilities are not relieved of their required discharge planning activities.
>
> **5.2 TRANSITION SERVICES**

Transition services are one-time expenses necessary to assist a nursing facility resident in moving to a home or similar community setting. Examples of transition services that the waiver agency could provide are in the Services section of this chapter.

* * *

The MI Choice waiver agency must work with the nursing facility resident to develop a transition plan that includes all projected transition costs. The plan must be based on individual goals and needs and must be included in the nursing facility resident's MI Choice record. It must be updated to reflect any changes.

For the contract period, MDHHS will reimburse the waiver agency for prudent and allowable transition expenses and supports coordination costs in accordance with Nursing Facility Transition Guidelines. As specified in the contract between MDHHS and the waiver agency, the waiver agency must notify MDHHS of its intention to transition a nursing facility resident to the MI Choice program when initiating a nursing facility transition plan. Procedures for notification are obtained from the MI Choice program contract manager. (Refer to the Directory Appendix for additional information.) The waiver agency must demonstrate the nursing facility resident has a Medicaid application pending with MDHHS or has been approved for Medicaid and meets MI Choice program criteria. Once the participant is enrolled in the MI Choice program, MDHHS will issue payment to the waiver agency for CTS. Non-waiver nursing facility transition funding is available for those who do not enroll in the MI Choice program upon transition or do not transition.

MPM, October 1, 2016 version
MI Choice Waiver Chapter, page 26

SECTION 4 – SERVICES

The array of services provided by the MI Choice program is subject to the prior approval of CMS. Waiver agencies are required to provide any waiver service from the federally approved array that a participant needs to live successfully in the community, that is:

- indicated by the current assessment;
- detailed in the plan of service; and
- provided in accordance with the provisions of the approved waiver.

Services must not be provided unless they are defined in the plan of service and must not precede the establishment of a plan of service. Waiver agencies cannot limit in aggregate the number of participants receiving a given service or the number of services available to any given participant. Participants have the right to receive services from any willing and qualified provider.

MDHHS and waiver agencies do not impose a copayment or any similar charge upon participants for waiver services. MDHHS and waiver agencies do not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Although MI Choice participants must have services approved by the waiver agency, participants have the option to select any participating provider in the waiver agency's provider network, thereby assuring freedom of choice.

Where applicable, the participant must use Medicaid State Plan, Medicare, or other available payers first. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

MPM, October 1, 2016 version
MI Choice Waiver Chapter, page 10

SECTION 9 – PROVIDERS

Authorization for provision of services is the responsibility of the waiver agencies. They determine the status of the qualifications and certifications (if applicable) for all direct service providers, negotiate and enter into contracts with the providers, and reimburse providers.

9.1 ENROLLMENT OF SERVICE PROVIDERS

Waiver agencies must use written contracts meeting the requirements of 42 CFR 434.6 to purchase services. Entities

or individuals under subcontract with the waiver agencies must meet provider standards defined in the Minimum Operating Standards for MI Choice Waiver Program Services which is maintained by MDHHS and attached to each annual waiver agency contract. Only providers meeting the requisite waiver requirements are permitted to participate in the waiver program.

To assure network capacity, as well as choice of providers, each waiver agency must have a provider network with capacity to service at least 125% of their monthly slot utilization for each MI Choice service and at least two providers for each MI Choice service. When waiver agencies cannot assure this choice within 30 miles or 30 minutes travel time for each enrollee, they may request a rural area exception from MDHHS.

9.2 FAMILY MEMBERS AS SERVICE PROVIDERS

Waiver agencies may pay relatives of MI Choice participants to furnish services. This authorization excludes legally responsible individuals and legal guardians. The MI Choice participant must specify his/her preference for a relative to render services. The relative must meet the same provider standards as established for non-related caregivers. All waiver services furnished shall be included in the plan of service and authorized by the supports coordinator. The supports coordinator must periodically evaluate the effectiveness of the relative in rendering the needed service. If the supports coordinator finds that the relative fails to meet established goals and outcomes or fails to render services as specified in the plan of service, the supports coordinator must rescind the authorization of that relative to provide waiver services to the participant. When the supports coordinator finds the relative has failed to render services, payments must not be authorized.

9.3 REIMBURSEMENT RATES FOR PROVIDERS

Each waiver agency is responsible for sub-contracting with provider entities and for assuring access to services. The process of rate determination for providers resides in the contract negotiation between the waiver agency and the provider. MDHHS does not play a role in this process.

Rates paid for services provided through the waiver must be adequate to assure access to services needed by participants.

MDHHS does not make payment to legally responsible individuals for furnishing Community Living Supports or similar services.

MPM, October 1, 2016 version
MI Choice Waiver Chapter, pages 34-35

11.1.A. ADEQUATE ACTION NOTICES

MI Choice waiver agencies must send an Adequate Action Notice to applicants or participants informing them of adverse actions and determinations taken under the following circumstances:

- when the waiver agency is at operating capacity and unable to enroll MI Choice applicants who request a Michigan Medicaid Nursing Facility Level of Care Determination (LOCD).

- when the waiver agency determines applicants to be functionally ineligible for MI Choice services based on the results of a LOCD.

- when a participant requests additional services or additional amounts of services and the waiver agency denies the request

MPM, October 1, 2016 version
MI Choice Waiver Chapter, page 39

Here, Petitioner was approved for the MI Choice Waiver Program while she was still in a nursing facility and a per diem rate for services in an [redacted] home was verbally identified. Moreover, while Petitioner and the [redacted] home disputed the amount of that per diem rate, Petitioner eventually signed the agreement in this case, moved into her AFC home, and filed the request for hearing in this case.

In response to the request for hearing, Respondent's representative argued that there was no negative action that would warrant an adequate action notice in this case or give rise to the right to a hearing as Petitioner had the opportunity to remain in nursing facility and to continue to work with Respondent in finding a home that would accept the approved per diem rate rather than move when she did. Respondent's NFT Team Lead

likewise testified that Petitioner only wanted the one particular [redacted] home and that the services covered by the per diem rate, which included bathing, dressing, a.m. care, p.m. care, transferring, and toileting assistance, were sufficient to meet Petitioner's needs. Respondent's representative further testified that the AFC home involved in this case will soon no longer be part of Respondent's provider network.

Petitioner's representative testified that she filed the appeal the moment she received verbal notification of the approved amount and that Petitioner needs assistance with everything. She also testified that Petitioner needed this [redacted] home because she is only comfortable in a [redacted] speaking home. Petitioner's representative further testified that whatever happens between the [redacted] home and Respondent in the future has nothing to do with this case.

The AFC home owner also testified that the home did its own assessment regarding Petitioner's needs and that the per diem rate approved by Respondent is insufficient to cover the services the [redacted] home provides. She further testified that the [redacted] home did accept the approved per diem rate, but that it also highlighted the differences between the two assessments at the time and indicated that it is not enough. The [redacted] owner also testified that its lawyers are appealing the termination of its contract with Respondent.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred by denying her request for additional services.

Given the record in this case, the undersigned Administrative Law Judge finds that Petitioner has failed to meet that burden of proof and that Respondent's actions must therefore be affirmed. As a preliminary matter, it is not clear that there is even a proper negative action at issue in this case as the dispute appears to be over the amount of the per diem rate paid to the AFC home and, while rates paid for services provided through the waiver must be adequate to assure access to services needed by participants, disputes between providers and the Waiver Agency are beyond the scope of this proceeding; Petitioner chose to go to a particular AFC home when she had the option of working with Respondent to go elsewhere; and the AFC home agreed to accept the per diem rate offered by Respondent.

Nevertheless, the record does suggest that Petitioner and her representative were disputing the per diem rate at least in part on the basis that insufficient services were authorized and such an action is within the undersigned Administrative Law Judge's jurisdiction. However, to the extent Petitioner's request for additional services should even be considered, there is insufficient evidence demonstrating that Petitioner needs more services given the significant amount of services already encompassed by the per diem rate and the lack of any specific details or support for claims that Petitioner needs more.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Petitioner failed to demonstrate that Respondent erred in authorizing services for Petitioner.

IT IS THEREFORE ORDERED that

The Respondent's decision is **AFFIRMED**.

SK/tm

Steven Kibit
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS -Dept Contact

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]